POWER OF ATTORNEY FOR PAYEE

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, _____ hereby appoints
(*Print Provider's Name)*

_____, _____,
(*Print Payee's Name*) *(Taxpayer Identification Number)*

as attorney-in-fact for the benefit of Provider and in Provider's name, place, and stead for the following purpose:

To receive, as Payee, any reimbursement from the Department of Community Health, Division of Medical Assistance to which Provider may be entitled as an enrolled provider.

Provider agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.

Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted, and in no way forecloses the application of penalties that may be accessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This _____ day of _____, in the year _____.

_____
Printed Name of Provider

By:

_____
Signature of Provider or Authorized Representative

_____
Title of Authorized Representative

Sworn to and subscribed before me

this _____ day of _____,

in the year _____.

_____
(Notary Public)

My Commission expires: _____